The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Glenmachan Tower House**

Provider: **Glenmachan Tower Ltd**

Date of Inspection: **26 November 2025 & 27 November 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Glenmachan Tower Ltd
Responsible Individual:	Mr Conor O Brien
Registered Manager:	Mrs Kathleen Chambers

Service Profile –

Glenmachan Tower is a registered nursing home which provides nursing care for up to 39 persons.

The bedrooms are situated over two floors. There is access to various communal spaces such as lounges, dining areas and gardens.

2.0 Inspection summary

An unannounced inspection took place on 26 November 2025 from 10.30am to 6.00pm, completed by a care inspector and on 27 November 2025 from 10.20am to 3.45pm, completed by a pharmacist inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 14 June 2023 and medicines management inspection on 21 January 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to monitoring and recording the temperature of the medicine storage areas and the management of insulin.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

As a result of this inspection, all areas for improvement were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients who were able to share their opinions on life in the home said or indicated that they were well looked after. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Relatives spoken with told us, they were satisfied with the care and services provided to their loved ones.

Responses received from the patient/relative questionnaires indicated they were happy with the care and services provided in Glenmachan; comments included "very happy with the care",

where additional comments were made, these were shared with the manager for review and action as appropriate. There was no additional feedback received from online staff questionnaires.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Bespoke care arrangements were in place for some patients and staff were observed supporting patients with their assessed care needs. Patients who required bespoke care had individualised care plans in place and staff spoken with were knowledgeable about the patient's needs.

Staff told us that the patient's needs and wishes were important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known.

Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

The risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Observation of the lunch time meal, review of records and discussion with patients, staff and the manager evidenced that there were robust systems in place to manage patients' nutrition and mealtime experience.

Arrangements were in place to meet the patient's social, religious and spiritual needs within the home. Activities for patients were provided which involved both group and one to one activities.

3.3.3 Management of Care Records

Patients' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred and regularly reviewed to ensure they continued to meet the patients' needs.

Patients' care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and welcoming. For example, patients' bedrooms had varying degrees of personalisation to reflect the patient's individuality. Bedrooms and communal areas were suitably furnished, warm and comfortable.

On review of the homes environment, excess storage was identified in one bathroom; this was addressed on the day of inspection and management confirmed that this would be routinely monitored.

Discussion with the management team confirmed that there was an ongoing refurbishment plan in place for the home; this will be reviewed at a future inspection.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records kept.

3.3.5 Quality of Management Systems

There has been a change of ownership of the home since the previous inspection which came into effect as of 8 October 2025 and Glenmachan Tower is operated by Glenmachan Tower Limited.

Mrs Kathleen Chambers has been the Manager in this home since December 2022.

Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. Discussion with the management team confirmed that some audits, where required, were being further developed to enhance oversight arrangements.

There was evidence that the management team responded to any concerns raised with them or by their processes.

3.3.6 Medicines Management

Monitoring and review of medicines management

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of distressed reactions, pain and thickening agents was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. However, for one patient, an in use insulin pen was not individually labelled and for

another patient the date of opening had not been recorded. In use insulin pens must be individually labelled to denote ownership and have the date of opening recorded to facilitate audit and disposal at expiry. An area for improvement was identified. An in use insulin pen on the medicines trolley still had a needle intact. This was discussed with staff for immediate corrective action and ongoing monitoring.

Supply, storage and disposal

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Review of the daily temperature records indicated that the temperature of all medicine storage areas were not monitored and recorded each day. Temperatures of all medicine storage areas must be monitored and recorded each day to ensure that medicines are stored appropriately at or below 25ºC. An area for improvement was identified.

Satisfactory arrangements were in place the cold storage of medicines, the storage of controlled drugs and the safe disposal of medicines.

Medicines administration

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines, which are subject to strict legal controls and legislation. They commonly include strong painkillers. The receipt, administration and disposal of controlled drugs should be recorded in a controlled drug record book. Controlled drugs were observed to be administered as prescribed and records maintained to the required standard.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. With the exception of insulin, the date of opening was recorded on medicines to facilitate audit and disposal at expiry.

Transfer of care

People who use medicines may follow a pathway of care that can involve both health and social

care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

Management of medicines incidents

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring.

Medicine management training

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	1

Feedback from the care inspection was discussed with the management team on 26 November 2025; and feedback from the medicines inspection was discussed with the management team, on 27 November 2025. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that in-use insulin pens are labelled to denote ownership and have the date of opening recorded to facilitate audit and disposal at expiry. Ref: 3.3.6
To be completed by: 27 November 2025	**Response by registered person detailing the actions taken:** All in use insulin pens are labelled with the service user's full name and the date of opening. Additional lebels have been requested from the pharmacy. Insulin pens are checked by the nurse at each medication round to ensure correct labelling and to confirm they remain within their safe use period.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that the temperature of all medicine storage areas is monitored and maintained at or below 25ºC. Ref: 3.3.6
To be completed by: 27 November 2025	**Response by registered person detailing the actions taken:** Thermometers are in place in all medicine storage areas. Daily temperature monitoring is recorded. Staff have been reminded of the required temperature threshold and the importance of accurate documentation. A clear escalation process is in place for any temperature readings above 25°C, including immediate corrective actions such as improving ventilation, using portable cooling equipment, and notifying management.

Please ensure this document is completed in full and returned via the Web Portal

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